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ARIZONA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF BIRTH

State File No. 9128

Registered No. 9

1. PLACE OF BIRTH

County _Gila_   State _Arizona_

District or Township _____ or Village _____

City _Miami_   No. _1126 Live Oak St._   St., _____ Ward
(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child _Ramon Preciado_
{ If child is not yet named, make supplemental report, as directed.

3. Sex of Child _Male_ | To be answered ONLY in event of plural births. | 4. Twin, triplet or other _____ | 6. Legitimate? _yes_ | 7. Date of birth _Jan. 4 - 1930._
| | 5. No., in order of birth _____ | | Month Day Year

8. FATHER	14. MOTHER
Full name _Adolfo Preciado_	Full maiden name _Augustina Saenz_
9. Residence (Usual place of abode) _Miami, Arizona._ If non-resident, give place and state.	15. Residence (Usual place of abode) _Miami Arizona._ If non-resident, give place and state.
10. Color or race _Mex._	11. Age at last birthday _27_ (Years)	16. Color or race _Mex._	17. Age at last birthday _29_ (Years)
12. Birthplace (city or place) _Sonora Mex_ (State or country)	18. Birthplace (city or place) _Parral, Chih. Mex_ (State or country)
13. Occupation Nature of Industry _Miner_	19. Occupation Nature of Industry _Housewife_

20. Number of children of this mother _2_
(Taken as of time of birth of child herein certified and including this child.)

(a) Born alive and now living _2_
(b) Born alive but now dead _0_
(c) Stillborn _0_

21. Were precautions taken against ophthalmia neonatorum? _yes_

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _born alive_ at _11-0_ .m .on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Given name added from a supplemental report _____
Month, day, year _____

Signature _Cyril M. Crow M.D._
Physician
(Physician or midwife.)

Address _Miami, Arizona_

Filed _Jan 1Y_ 19 _30_   _C. E. ___

Registrar.   Registrar.